CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	
Mercy Hospital	**Claim for Cost Reporting Period Ending: December 31, 2002, December 31, 2003, December 31, 2004**
Providers	
vs.	
First Coast Service Options, Inc./ Blue Cross and Blue Shield Association	**Review of PRRB Dec. No. 2015-D7**
Intermediary	**Dated: April 3, 2015**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Comments were submitted by the Medicare Administrative Contractor (MAC) and the CMS' Center for Medicare (CM) requesting that the case be dismissed for lack of jurisdiction. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Provider requesting affirmation of the Board's decision. Further comments were received from the MAC. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

Issues and Board Decision

Issue No 1 is whether the Board has jurisdiction to review the MAC's determination that the days of patients who were eligible for medical assistance under an approved Medicaid State plan and enrolled in a Medicaid plus Choice plan under Part C of

Medicare should be excluded from the Medicaid fraction of the low-income percentage (LIP) adjustment for the Provider's inpatient rehabilitation facility (IRF).[1]

Issue No 2 is whether the Medicare Administrative Contractor (MAC) properly determined the Provider's LIP adjustment under the prospective payment system (PPS) for IRFs for the Provider's cost reporting periods ending in 2002, 2003, and 2004. The MAC excluded from the Medicaid fraction of the LIP adjustment the days of the patients who were eligible for medical assistance under an approved Medicaid State plan and enrolled in a Medicaid plus Choice plan under Part C of Medicare.[2]

Regarding Issue No.1, the Board concluded that section 1886(j)(8)(B) of the Social Security Act does not preclude review by the Board in this case. The Board disagreed with the MAC that the prohibition of section 1886(j)(8)(B) of the Act encompasses both the general IRF-prospective payment system (PPS) rate and any and all adjustments to those rates including the low income payment or LIP adjustment. The Board concluded that the phrase in section 1886(j)(8)(B) prohibiting review of "the prospective payment rates under paragraph (3)" does not encompass all of paragraph (3) but is limited to general rates prior to being adjusted by the matters enumerated in clauses (i) through (v). The LIP adjustment was promulgated pursuant to clause (v). Therefore, the prohibition does not extend to the LIP adjustment. The Board also found significant that the Provider was not challenging the "establishment" of the items listed in subparagraph (A) and (B), but rather the LIP adjustment which was established in the final rule. The Board distinguished between the terms "certain factors" for which review is prohibited and "other factors". For the years at issue, CMS promulgated a regulation prohibiting review which referred to unadjusted Federal payment rates and had an established practice of allowing review of LIP issues, which cannot be changed except through prospective notice and comment rulemaking.

Regarding Issue No. 2 the Board concluded that the methodology and formula for determining the LIP is identical to that for determining the DSH payment under inpatient prospective payment system (IPPS) and thus is bound by the controlling law. The Board found that the law set forth in *Northeast Hospital Corporation v. Sebelius*, 637 F. 3rd 1 (D.C. Cir. 2011) is controlling. The Board, therefore, concluded that it was improper for the MAC to exclude from the Medicaid fraction of

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[1] The IRF is a subprovider of the hospital. *See e.g.* Provider's Request for a Hearing, dated March 12, 2007, Tab 2 , Adjustment 40 for Subprovider 2.

[2] The Provider also raised a constitutional challenge to the validity of the statutory prohibition of administrative and judicial review set forth at section 1886(j)(8) of the Act. A constitutional challenge is outside the scope of the Administrator's authority and will not be addressed in the decision.

the LIP adjustment for FY 2002. 2003 and 2004, the days of patients who were eligible for medical assistance under an approved Medicaid State plan enrolled in a Medicare plus Choice plan under Part C of the Medicare program and discharges prior to October 1, 2004.

Comments

The MAC submitted comments requesting that the case be dismissed for lack of jurisdiction. The Provider, an acute care hospital, operates an Inpatient Rehabilitation Facility or IRF. The Board erroneously found that there was jurisdiction over the Provider's appeals. The MAC maintained that section 1886(j)(8)(B) of the Social Security Act specifically precludes administrative and judicial review of the IRF PPS LIP adjustment. The general IRFF PPS rate is a product of the base rate that is based on the average payment per payment unit for inpatient operating and capital costs of the IRF as estimated by the Secretary and adjustments described under sections (i) through (v) of subsection 1886(j)(3)(A), including the LIP adjustment authorized under (v). In addition, regarding Issue No. 2, the Board also erroneously determined that the MAC improperly calculated the IRF LIP adjustment. The Board lacked authority to review that issue.

The CMS Centers of Medicare (CM) for similar reasons stated that the Board incorrectly found jurisdiction over this issue as the LIP adjustment is an integral part of setting the IRF payment rate. The plain language of the statute precludes review over the Federal prospective payment rate for IRFs. In this appeal, the Provider seeks administrative review of the Federal prospective payment rates established for FY 2002, 2003, and 2004. Specifically, the Provider wants those payment rates increased by including the days of the patients enrolled in Medicare Part C in the Medicaid part of the calculation of the LIP adjustment. The CM stated that the reference in section 1886(j)(8)(B), to section 1886(j)(3), necessarily includes all of section 1886(j)(3) in the absence of any modifying language. While the Board maintained that review is only excluded for the "unadjusted" Federal prospective payment rate, that term is not what the statutory language states, as that word "unadjusted" was omitted from section 1886(j)(8)(B). Congress could have, as in the capital PPS rate at section 1886(g)(1)(A) of the Act, unambiguously limited the prohibition in that manner by adding that term, but it did not do so in section 1886(j)(8)(B). CM pointed out that the prohibition applies to all of paragraph (3). CM also pointed out that it is not redundant to find that the prohibition includes all of paragraph (3), which refers to the area wage as an adjustment under that section and also prohibited under section 1886(j)(8)(D) which specifically references the section 1886(j)(6) computation of area wages. Such a reading does not render the reference to the wage index adjustment review prohibition in section 1886(j)(8)(D) meaningless (prohibiting the review of the wage index under section 1886(j)(6)) as paragraph (6) sets the

productivity with which the wage index must be reset and imposes a budget neutrality requirement. If not also included specifically under section 1886(j)(8)(D), providers may have argued these components of the wage index are reviewable.

Further, CMS stated that the Board incorrectly determined that the original poorly drafted language of 42 CFR 412.630 limited the prohibition for review to the unadjusted rates only and allowed review of the LIP adjustment. To the extent the regulatory language could be construed to have permitted review where it would otherwise have been precluded by statute, the broader statutory preclusion must be given full effect over the regulation. CM concluded that administrative and judicial review of the LIP adjustment is precluded by section 1886(j)(8)(B) of the Act and the Board decision should be dismissed on jurisdictional grounds.

If the merits were to be reached, CM maintained that the Part C days should be excluded from the numerator of the Medicaid fraction of the LIP adjustment. The Secretary explained that in establishing the policy in the FFY 2002 IRF PPS final rule, CMS adopted "the percentage of low-income patients *currently* used for the acute care hospital [IPPS] which is the DSH variable." (Emphasis added.) (66 Fed. Reg. 41316 at 41360.) It was never CMS policy to allow these days in the numerator, nor to have a policy to allow them retroactively to be included pursuant to an unfavorable court case involving the Medicare DSH calculation.

The Provider submitted comments requesting affirmation of the Board's decision for all of the reasons set forth in the Board's decision as well as the Provider's filings with the Board herein incorporated by reference.

Discussion

Section 1886(d)(1)(B) of the Social Security Act (the Act) and Part 412 of the Medicare regulations define a Medicare certified hospital that is paid under the inpatient (acute care hospital) prospective payment system (IPPS). However, the statute and regulations also provide for the classification of special types of Medicare certified hospitals that are excluded from payment under the IPPS. These special types of hospitals must meet the criteria specified at subpart B of Part 412 of the Medicare regulations. Failure to meet any of these criteria results in the termination of the special classification, and the facility reverts to an acute care inpatient hospital or unit that is paid under the IPPS in accordance with all applicable Medicare certification and State licensing requirements.

One of the special types of hospitals excluded from the IPPS is an inpatient rehabilitation facility (IRF). The inpatient rehabilitation facility or IRF is an inpatient rehabilitation hospital or a unit, which provides an intensive rehabilitation program to

inpatients. IRF provides skilled nursing care to inpatients on a 24-hour basis, under the supervision of a doctor and a registered professional nurse. The IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.[3]

Pursuant to section 4421 of the Balanced Budget Act of 1997[4], Congress established the IRF PPS for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act authorized the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals (or Critical Access Hospitals [CAHs]), collectively known as IRFs. As required by Section 1886(j) of the Act, the Federal rates reflect all costs of furnishing IRF services (routine, ancillary, and capital related). With respect to the "prospective payment rates", section 1886(j)(3) of the Act states:

> (3) *Payment rate*.—
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> (A) *In general*.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—
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> (i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;
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> (ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);

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[3] *See* Medicare Benefits Manual section 110.

[4] Pub Law No. 105-33.

(iii) *for variations among rehabilitation facilities by area under paragraph (6);*

(iv) by the weighting factors established under paragraph (2)(B); and

(v) *by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.* (Emphasis added.)

Further section 1886(j)(6) sets forth the area wage adjustment:

> 6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. *Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor* under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. *Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.*

Thus, while the payment rate paragraph at section 1886(j)(3) cross references the wage area provision as an adjustment, section 1886(j)(6) in detail specifies the wage area adjustment and the requirements of its productivity and budget neutrality components.

In implementing the Federal payment rates, the Secretary promulgated regulations at 42 CFR 412.624, which state that:

> (e) Calculation of the adjusted Federal prospective payment. For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to

> account for area wage levels, payments for outliers and transfers, and for other factors as follows:
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> (1) Adjustment for area wage levels. The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602. Adjustments or updates to the wage data used to adjust a facility's Federal prospective payment rate under paragraph (e)(1) of this section will be made in a budget neutral manner. CMS determines a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.
> (2) Adjustments for low-income patients. We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.

The regulation provision at 42 CFR 412.624(e)(2) providing for the LIP adjustment was authorized pursuant to section 1886(j)(3)(A)(v) of the Act. The Secretary, in explaining the methodology, stated that:

> We proposed to use the same measure of the percentage of low-income patients *currently* used for the acute care hospital inpatient prospective payment system, which is the DSH variable. The low-income payment adjustment we chose improves the explanatory power of the IRF prospective payment system because as a facility's percentage of low-income patients increases, there is an incremental increase in a facility's costs. We proposed to adjust payments for each facility to reflect the facility's percentage of low-income patients using the DSH measure.[5]

In creating new paragraph (j), Congress also specified that there was a limitation on administrative and judicial review with respect to the IRF PPS payment rates. Specifically, section 1886(j)(8) of the Act[6] provides:

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[5] 66 Fed. Reg. 41316, 41359 (August 7, 2001).

[6] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act to section 1886**(j)(**8**)** and inserted a new section 1886(j)(7),

(8) Limitation on review.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the prospective payment rates under paragraph (3),

(C) outlier and special payments under paragraph (4), and

(D) area wage adjustments under paragraph (6).

In originally promulgating the regulation at 42 CFR 412.630, the proposed §412.630 specified that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index. The regulation at 42 CFR 412.630 stated regarding the "Limitation on Review" that:

> Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

However, in the FFY 2014 Final IRF rule, consistent with the proposed rule pronouncement,[7] the Secretary clarified the language of 42 CFR 412.630 to be in full

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which contains new requirements for the Secretary to establish a quality reporting program for IRFs.

[7] *See* IRF PPS FFY 2014 proposed rule at 78 Fed. Reg. 26880, 26908 (May 8, 2013) ("XI. Proposed Clarification of the Regulations at §412.630 In the original rule establishing a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital, we stated that that there would be no administrative or judicial review, under sections 1869 and 1878 of the Act or otherwise, of the establishment of case-mix groups, the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments. See 66 FR 41316, 41319 (August 7, 2001). Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the

accord and accurately reflect the scope of section 1886(j)(8) of the Act.[8] The Secretary explained that:

> XII. Clarification of the Regulations at § 412.630
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> In the original rule establishing a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital, we stated that that there would be no administrative or judicial review, under sections 1869 and 1878 of the Act or otherwise, of the establishment of case-mix groups, the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments. See FY 2002 IRF PPS final rule (66 FR 41316, 41319). Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at § 1886(j)(8) of the Act to apply to all payments authorized

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preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at section 1886(j)(8) of the Act to apply to all payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are proposing to clarify our regulation at § 412.630 by deleting the word "unadjusted" so that the regulation would clearly preclude review of "the Federal per discharge payment rates." This clarification will better conform the regulation to the statutory language. As such, in accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are proposing to revise the regulations at § 412.630 to clarify that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.")

[8] 78 FR 47860, 47899-47901 (August 6, 2013). *See also* 78 Fed Reg. 47864,("*B. Proposed Revisions to Existing Regulation Text* …• Clarifications to § 412.630, to reflect the scope of section 1886(j)**(**8**)** of the Act, as described in section XI. of the FY 2014 IRF PPS proposed rule (78 FR 26880 at 26908).")

> under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are clarifying our regulation at §412.630 by deleting the word "unadjusted" so that the regulation will clearly preclude review of "the Federal per discharge payment rates." This clarification will provide for better conformity between the regulation and the statutory language.
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> As such, in accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are revising the regulations at § 412.630 to clarify that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

The Secretary specifically addressed the characterization of the change as a clarification of the regulation at 42 CFR 412.630, stating that:

> We received two comments on the proposed clarification of the regulations at § 412.630, which are summarized below.
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> Comment: The commenters expressed concerns with our proposal to revise the regulations at 42 CFR 412.630 to clarify that the Medicare statute precludes administrative and judicial review of the Federal per discharge payment rates, including the LIP adjustment. One commenter stated that the proposal is not a "clarification" that can be applied to pending cases, is inconsistent with the statute, runs afoul of the presumption of judicial review, fails to give proper notice of the regulatory change, and is unconstitutional.
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> Response: We disagree with the commenter's statements. Our proposed change serves to clarify the regulation so that it clearly reflects the preclusion of review found in the statute. It also removes any doubt as to the conformity of the regulation to the preclusion of review found in the statute, which by its own terms is applicable to all pending cases regardless of whether it is reflected in regulations or not.
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> We also strongly disagree with the commenter's reading of the statute. Section 1886(j)(8) of the statute broadly precludes review of "the prospective payment rates under paragraph (3)," that is, section

1886(j)(3). Within this section, subsection 1886(j)(3)(A) authorizes certain adjustments to the IRF payment rates and, within that, subsection 1886(j)(3)(A)(v) authorizes adjustments to the rates by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." The LIP adjustment is made under authority of section 1886(j)(3)(A)(v). As that provision is contained within section 1886(j)(3), and the IRF payment rates under section 1886(j)(3) are precluded from review by section 1886(j)(8), the LIP adjustment falls squarely within the statutory preclusion of review. Such preclusion overcomes any presumption of reviewability that might generally apply, and it is not unconstitutional for Congress (which has the power to define the jurisdiction of the federal courts) to preclude review of certain issues as it has done here. Several virtually identical preclusions of review in other sections of the Medicare statute have been repeatedly upheld and applied by federal courts. Finally, as to notice, the proposed rule itself served as notice of our intention to revise the regulation. In addition, as discussed below, the longstanding language of the statute itself provides sufficient notice to apply the preclusion.

Comment: One commenter stated that our proposal cannot be a clarification because we have allowed review of matters concerning the LIP adjustment for many years. This commenter further stated that any preclusion of review should apply only to the "formulas" used in the IRF payment rates, and that to preclude review would prevent providers from correcting errors in their payments and would result in two separate methods being used to pay IRFs and hospitals paid under the inpatient prospective payment system (IPPS).

Response: We disagree with these comments. The preclusion of review has been effective since its enactment as part of the IRF prospective payment system in 2002. No regulation or revision of any regulation was necessary for the statutory preclusion to become effective, regardless of whether we or our contractors may have participated in review of IRF LIP matters in the past without making a jurisdictional objection. To the extent that such erroneous participation may have occurred, it does not override the mandate of the statute or prevent us from immediately applying the statutory preclusion of review.

In addition, the preclusion applies to all aspects of the IRF PPS payment rates, not just the formulas. Courts have applied nearly identical preclusion provisions in other parts of the Medicare statute to

> prevent review of all subsidiary aspects of the matter or determination protected from review. Finally, while precluding review of the IRF LIP adjustment may prevent correction of certain errors, we can only conclude that Congress has made the judgment that such a result is an appropriate trade-off for the gains in efficiency and finality that are achieved by precluding review. Similarly, although applying the preclusion here may result in certain questions being reviewable for an IPPS hospital but not an IRF, this is a judgment that Congress has made. We note that there is a preclusion of review provision in the IPPS statute also, at section 1886(d)(7). The precise contours of these preclusive provisions were for Congress to draw.
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> Final Decision: After careful review of the comments we received on the clarification of the regulations at §412.630, we are adopting our proposal to revise the regulations at 42 CFR 412.630 to clarify that the Medicare statute precludes administrative and judicial review of the Federal per discharge payment rates under section 1886(j)(3), including the LIP adjustment. This revision to the regulation is effective October 1, 2013.

Thus 42 CFR 412.630 was revised to read as follows:

> Limitation on review.
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> Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.[9]

The Provider maintains that, as there is a presumption that Congress generally intends to provide for review unless specified otherwise, section 1886(j)(8) of the Act should be read narrowly to only prohibit review of the "unadjusted" IRF PPS Federal per discharge payment rate. As the LIP is an adjustment to the payment rate, and the LIP is the matter under appeal, the prohibition does not apply to this appeal. The Provider also points to the original language of the regulation which it states is controlling in this case and limits the preclusion only to the "unadjusted" payment rate. The Provider also points to court cases that it maintains support that Congress does not intend to shield executive branch decisions made discretionary by

[9] 78 Fed. Reg. 47933.

regulation, and not by statute, and that the LIP is a CMS established discretionary adjustment and hence should not be shielded from review. The Provider states that the Board also cannot depart from the agency's rule and established practice. The established practice is that CMS has allowed for review of LIP adjustment appeals in the past. The Provider argues that similar issues have been resolved before the Board pursuant to administrative resolutions and hence jurisdiction is not a bar to jurisdiction in this case as it has been established by Federal administrative common law. Finally, a change in the policy, which would be involved here based on past practices, even if a permitted interpretation, cannot be applied retroactively.

The Administrator finds that the determination at issue is integral to the calculation of the Federal per discharge payment rate. The LIP is authorized under section 1886(j)(3)(A)(v) of the Act and is a component of the Federal per discharge payment rate as authorized under section 1886(j)(3) of the Act. Section 1886(j)(8)(B) of the Act specifically prohibits the administrative or judicial review under section 1878 of the Act of the "payment rate as provided for under paragraph (3) [section 1886(j)(3)]". As section 1886(j)(8) precludes review of matters under paragraph (3) and the LIP calculation is provided for under paragraph (3), administrative and judicial review is precluded of that matter.

Moreover, not only does the plain language of the statute support that Congress intended no review under the facts set forth in this case, but regardless of the Provider's characterization of its challenge, allowing review would render section 1886(j)(8)(B) of the Act void, as noted by several courts under similar situations. Courts have applied nearly similar preclusion provisions in other parts of the Medicare statute to prevent review of all subsidiary aspects of the matter or determination protected from review.[10] Thus, the Administrator finds that the appeal

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[10] *See, e.g., Am. Soc. of Anesthesiologists v. Shalala*, 90 F.Supp.2d 973, 975 (March 31, 2000) ("…[T]he 'strong presumption that Congress intends judicial review of administrative action'…comes into play only where there is a legitimate question as to congressional intent…there is no room for employing that presumption approach where…Congress has been so explicit in stating a prohibition against judicial review.") In *Am. Soc. Of Anesthesiologists*, the Associations were arguing that there was a dichotomy between nonreviewable matters and reviewable matters. As the Court noted, "…it simply will not do for Associations to say 'Oh, we're only challenging Secretary's decisions that must be made before the relative value and relative value unit determinations'… If Associations' position were accepted, the congressional mandate against court intervention would be totally frustrated, because the opportunity for parties such as Associations to launch in-court attacks on the individual strands—the specific items—that are both integral and essential components of the congressionally-protected determinations that Secretary must

raised in this case falls under the statutory bar to limitations on review of section 1886(j)(8) of the Act.

The Administrator also finds that the regulatory change clarified the regulation when removing the inadvertently included term "unadjusted" and thoroughly discussed and explained that this was not a new policy. The preclusion of review is mandated by the statute, which by its own terms, is applicable to all pending cases. As the Provider acknowledged, the Secretary's scope of authority is determined by the statute. Just as the Secretary cannot limit Board jurisdiction prescribed by Congress, the Secretary cannot expand Board jurisdiction specifically precluded by Congress. A reading of the regulation to do so would be contrary to the clear mandated prohibition set forth at section 1886(j)(8) of the Act.

Likewise, any administrative resolution in prior cases pursuant to the appeal mechanism of section 1878 of the Act by the MACs and/or CMS would not have been authorized by the statute and does not alter the plain reading of the statute prohibiting such review, nor authorize review in this case.[11] Such does not constitute a practice that can override the plain language of the statute and confer jurisdiction where the statute specifically prohibits jurisdiction for administrative and judicial review.[12]

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make would defeat her ability to make the determinations themselves." *See also Fischer v. Berwick*, Slip Copy, 2012 WL 1655320, D.Md.,2012 (May 09, 2012), *aff'd*, 2013 WL 59528, 4th Cir. (Md.) (Jan 07, 2013). *See also Am. Soc'y of Cataract & Refractive Surgery v. Thompson*, 279 F. 3d 447 , 452 (7th Cir. 2002); *Skagit Cnty. Pub. Hosp.. Dist. No. 2 v. Shalala*,. 80 F3d 379 (9th Cir 1996).

[11] Further, the inadvertent granting of jurisdiction in an administrative proceeding, on a matter where none exist, is not a bar to the correction of that error by the agency before the courts in that case. *See, e.g.*, *Florida Health Science v. Secretary*, Civil Action No. 14-0791(ABJ) at n. 3 (March 31, 2015)(where the Board had granted jurisdiction). Similarly, the inadvertent granting of jurisdiction in an earlier administrative proceeding, where none exist, does not prohibit the assertion of a jurisdictional bar in a later case. This would be contrary to the general administrative law principle that an administrative agency cannot enlarge its own jurisdiction, which the Board and Provider are suggesting an agency may do in this case based on erroneous prior administrative resolutions.

[12] Moreover, while the Board relies upon *Alaska Prof'l Hunters Ass'n v. FAA*, 177 F. 3d 1030 (D..C.Cir.1999), the Supreme Court has since spoken in *Perez v. Mortgage Bankers Ass'n*, 575 U.S. ___ (2015) (Nos. 13-1041, 13-1052), addressing the *Alaska Prof'l Hunters* holding with respect to an agency's change in a "long standing and definitive interpretation" of a rule.

The interpretation of the statute adopted by the Board is contrary to the plain language of the statute. Contrary to the Board's contention, there is no term "unadjusted" set forth in the applicable statutory language limiting the preclusion of review to the "unadjusted" "prospective rates under paragraph (3)."[13] The Board next asserts that only the specific adjustments listed in section 1886(j)(8)(A), (C) and (D) are precluded from review. The Board found that if Congress intended the adjustments cross-referenced under paragraph (3) to be shielded from review it would have been unnecessary to set forth the specific preclusion of certain adjustments at section 1886(j)(8)(A), (C) and (D) of the Act. But that presumes, among other things, these references are identical, perform the same purpose and function and, hence, are redundant. For example, while section 1886(j)(3)((A)(iv) refers to the adjustment for case mix and weighting factors under section 1886(j)(2)(B) being applied, the case mix provision at (2) includes paragraphs (A) and (C). In addition, as CMS pointed out, reference to paragraph (6) at section 1886(j)(8)(D) ensures that, *inter alia*, the budget neutrality component set forth in (6) is shielded from review. Conversely, if the specific adjustment provisions were not also cross-referenced at section 1886(j)(8)(A), (C) and (D), it no doubt would have been actively argued by the Provider that Congress clearly did not intend these adjustments or any adjustment components to be shielded from review.[14]

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[13] In addition, not only does the preclusion at section 1886(j)(8) refer to paragraph (3) without limitation, but the *general description* of the "payment rate" under paragraph (3)(A) includes the description of the adjustments under (i) through (v). Further, to look to provisions of other parts of the Medicare statute for guidance as the Board does, ignores the plain language of the controlling statute. Finally, the prohibition of limiting review of regulatory "discretionary" decisions referred to in *Kucana v. Holder*, 558 U.S. 233 (2010), appears distinguishable from the authority accorded the Secretary in implementing the Medicare program. Wide authority is generally afforded, within the statutory parameters given by Congress, for the Secretary to implement the Medicare program, including through the use of notice and comment rulemaking, which in this case included the authority to implement the payment rates within the statutory parameters laid out at section 1886(j)(3) including the specified parameters Congress set forth at subclause (v). Indeed, subclause (v) does set out specific parameters for the Secretary to follow when it states: "such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." Within the authority and guidance granted by Congress through the statute, the IRF PPS payment rates, wage adjustment, and other adjustments and factors, not just subclause (v) in isolation, are all, in the end, implemented through, *inter alia*, rulemaking by the executive branch.

[14] The problem with stating that the term *expressio unius est exclusio alterius* or that the "expression of one thing is the exclusion of the other" applies to resolve this case in the Provider's favor, is that it ignores that the "prospective payment rate under

The Board's requirement is misplaced that a "new rule" would be required to be promulgated by notice and comment and be applied prospectively when the rule being applied here is an accurate reflection of the plain language of the statute since its enactment.

Finally, while the Board states it is bound by the regulation, the Board has, conversely, chosen not to be bound by the regulation as reflected pursuant to the FFY 2014 language change, promulgated through notice and comment rulemaking, and with extensive and specific explanation as to its promulgation as a clarification and, hence, applicable in this case. As the Secretary explained the longstanding language of the statute provides sufficient notice to apply the preclusion. The preclusion of review has been effective since its enactment as part of the IRF prospective payment system in 2002. No regulation or revision of any regulation was necessary for the statutory preclusion to become effective, regardless of whether CMS or its contractors may have participated in review of IRF LIP matters in the past without making a jurisdictional objection. To the extent that such erroneous participation may have occurred, it does not override the mandate of the statute or prevent CMS from immediately applying the statutory preclusion of review.

Consequently the Board's decision on Issue No 1 is vacated and dismissed. As the Administrator finds there is no Board jurisdiction on the LIP issue pursuant to Issue No 1, a decision on the merits of Issue No 2 is not within the Board's jurisdiction and is also vacated and dismissed.

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paragraph (3)", the phrase expressed or included in the "list" of items not subject to review, in turn, specifically includes the subclause (v). That is, one of the "defined terms" included or expressed, the "prospective payment rate under paragraph (3)", includes, among other things, as a subset subclause (v). Both the Board and the Provider erroneously start with the presumption that the "prospective payment rate under paragraph (3)" should be defined as the "unadjusted" payment rate, and thus does not include as part of its definition any adjustments, even though the term "unadjusted" is not used in that phrase and the definition of the phrase "prospective payment rate under paragraph (3)" is the basis for the dispute in this case.

Decision

Issue No. 1

The decision of the Board on Issue No. 1 finding jurisdiction over the LIP adjustment authorized under section 1886(J)(3) of the Act is vacated and dismissed**.**

Issue No. 2

As the Administrator finds there is no Board jurisdiction on the LIP issue pursuant to Issue No 1, a decision on the merits of Issue No 2 is not within the Board's jurisdiction and is also vacated and dismissed.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 6/1/15

/s/

Patrick Conway, M.D.
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services